Springfield Medical Care Systems
Response to Review Committee Questions
Proposal for Psychiatric Acute Care Services to Replace Vermont State Hospital

1. **The proposal is for a new level of care-how can you provide the resources to staff the proposed inpatient program?**

   We believe there are two answers to the question of providing resources to staff the proposed inpatient program. First of all, there are financial considerations for the expense of additional staffing resources. We will need to receive a higher rate of reimbursement from Medicaid to care for patients requiring the proposed level of inpatient care. We would also be expecting to contract with the Department of Mental Health to cover the expenses of a higher level of care for those patients who may be uninsured. In addition, if a higher level of Medicaid reimbursement does not allow us to cover expenses in providing appropriate care to the patients requiring our service we would expect to contract with the Department of Mental Health to close the gap between reimbursement and expenses for those patients.

   Secondly, as we spoke about in our proposal, we have very low turnover of nursing staff at the Windham Center. We emphasize a recovery culture that involves and empowers staff. Our usual recruiting processes would be used to hire the additional staff needed for the various levels of care proposed. We have a competent and supportive Human Resource department to assist us. We also have strong orientation plans for staff as they are hired to the organization. We are familiar with physician recruitment and are connected with various agencies that assist us in that process. We believe the proposal in its entirety would be a positive recruitment tool for psychiatrists.

2. **Would you be willing to partner with Dartmouth on this project?**

   Springfield Medical Care Systems has a long history of collaboration with Dartmouth Hitchcock Medical Center. Our physicians often collaborate with Dartmouth physicians. Patients in need of tertiary care are transferred from our Emergency Department to DHMC. The Behavioral Health department at DHMC has referred patients to our Partial Hospitalization program as well as our Intensive Outpatient Program. We feel that DHMC has a great deal of respect for our Behavioral Health programs. We certainly would be willing to explore the possibility of partnering with DHMC to create this higher level of care within a continuum. We would also see this collaboration as a positive addition for recruitment of staff and psychiatrists.

3. **Is the inpatient proposal contingent on creating the crisis bed program? Would Springfield Hospital be willing to operate the proposed inpatient program without the crisis beds?**

   Springfield Medical Care System believes that the proposal is contingent on creating the crisis bed program. In a later question you ask about the impact of providing this higher level of care to our local and statewide system of care. The answer to that question will provide further clarity around the need for the development of the crisis bed program in addition to the development of the inpatient care. The continuum of care we envision in our proposal is consistent with some of the recommendations made in the consultants' Report on Clinical Services Design. We believe patients should be able to receive the appropriate level of care in a timely manner. The continuum we envision accomplishes that goal with the local availability of many options for patients.

   Having said all of that we would be willing to look at other arrangements for accomplishing a higher level of inpatient care, crisis stabilization beds, and intensive community based crisis intervention that would be easily accessible. Other options may include partnering with other entities or including a service in our continuum that already exists. These possibilities would be more thoroughly explored if there is serious consideration of moving forward with our proposal.

4. **How will the proposed program provide access to ECT?**

   We have not explored in detail how we would provide access to ECT. There are several possibilities available to us. We might consider contracting with an outside service. We may consider contracting with physicians from another hospital who are competent to provide ECT. We may develop our own internal competencies in this area. We easily and readily have the resources in our Anesthesia Department to provide the sedation for the procedure.

5. **Does adding ten crisis beds impact the critical access designation?**

   As we alluded to in our proposal we do not believe adding ten crisis beds would impact the critical access hospital designation. The crisis beds are not hospital level of care from a federal perspective. We would be very clear that the crisis beds are residential with appropriate supervision but not staffed as a hospital inpatient bed would be. Our CEO, Glenn Cordner, is pursuing various avenues to gain clarity on this issue. And, again, there may be other options to explore how we might include crisis beds in our continuum but not necessarily have them belong to Springfield Medical Care Systems.

6. **The proposal calls for re-tooling the existing program into VSH-replacement care. Please describe the impact of the loss of ten general psychiatric hospital beds on the local and statewide system of care.**

   Unless we can create a crisis stabilization level of care the loss of the ten general psychiatric hospital beds could be significant locally and to the statewide system. However, we believe with the additional resource of crisis stabilization beds that there are many patients who could be managed in such a setting with a full array of programming. Our goal would be to always provide the appropriate level of care in the appropriate setting. We also feel that there are a significant number of patients we currently care for on the inpatient unit that might avoid hospitalization with earlier intervention and services as well as intensive community based crisis intervention. Many of these patients do not qualify for CRT or other programs. The gap in services for consumers who do not qualify for CRT or other programs has been identified by both consumers and providers. The intensive community based crisis intervention is a cost effective mechanism for moving consumers through the acute care continuum and into more community based recovery services. Using the continuum of care that we are proposing our goal would be to serve as many patients as possible and minimize the impact as much as possible in re-creating our inpatient beds to Vermont State Hospital replacement beds.

7. **How would this change your focus of care? Will this reduce your co-occurring capability?**

   The only change in our focus of care would be to increase our capability and capacity to care for higher acuity patients. We would accomplish this through hiring staff qualified to care for higher acuity patients and increasing our resources to provide services. The Windham Center has a long history of being client centered, recovery oriented, and co-occurring disorder competent. Our programming and care would continue to be based on those principles as they are the philosophy that guides our entire service and earns the excellent reputation that the Windham Center has for being welcoming to clients with co-occurring disorders.

8. **Would the proposed 10-bed crisis stabilization program sufficiently replace the general psychiatry beds? Please provide more information about the justification for adding 10 crisis beds to the system of care.**

   We would not necessarily consider that the crisis stabilization unit would "replace" the general psychiatry beds. There will be patients who are much more appropriate for an inpatient admission than a crisis stabilization program. However, creating the crisis stabilization beds would help us to build a very effective service continuum in our community. Those patients who require an inpatient admission may be able to moved along the

continuum more quickly and effectively with the availability of crisis stabilization beds. Creating and implementing the continuum of care we are proposing is certainly easier and less expensive to implement than investing in new construction.

9. **Please describe in more detail how security issues would be addressed.**

   Security will be managed a variety of ways. Security will primarily be managed by anticipating and providing for patient needs with highly skilled staffing to assess and deliver patient care. Included in this approach will be a 3:1 patient to RN ratio and greater than 1:1 patient to clinical staff ratio. All staff will be trained in Management of Aggressive Behavior (MOAB) and just as importantly will be provided with training regarding trauma informed care, validation, maintaining a non-judgmental stance, and conflict resolution skills.

   We will also utilize structural security, single rooms with half-baths, large community areas, private treatment rooms, and visiting accommodations will be provided for the patients. Also, we will design multiple segmented units with secure outdoor space, sally ports, secure access for admissions, and a security team present on the grounds 24/7. Additionally; we will be employing the use of technology; including wireless call buttons, motion detectors, and electronic/remote locking systems.

10. **Can a 10-bed program for this level of intensive inpatient care be viable?**

    Again, this question may be answered in two ways. Financial viability will depend on the reimbursement rate and the rate structures within a contract with the Department of Mental Health. We included a brief financial analysis within our proposal. The financial analysis includes the reimbursement rate we feel we need to make the levels of care in the proposal viable. If our proposal is given serious consideration for moving forward a more in-depth financial analysis would be completed. Springfield Medical Care Systems would not be able to move forward unless there is assurance for the program to be viable. Secondly, a 10-bed program is absolutely viable from a clinical perspective. A small, community-based unit will be able to be more recovery oriented and more clinically flexible than a larger, more institutional unit.

11. **Given the legal requirement that care be provided in the least restrictive environment, as well as the State's policy of favoring voluntary care whenever possible, and the fact that the proposed program is specifically a high acuity, involuntary, and high security setting, how would the proposer ensure access to less restrictive and/or voluntary inpatient care when appropriate? No less restrictive unit would be available at the Windham Center.**

We would first assess the client for the level of care that would meet their needs. If the client were able to be moved to the crisis stabilization program we would offer that option. If they continued to need inpatient care at a less restrictive level we would look at transitioning them to a less restrictive unit in their own community. Client preference would be taken into consideration as much as possible.

Our impression is that the work that will be developing from the consultants' Report on Clinical Services Design would support assessing and moving patients to less restrictive care where it is available in the system. The development of a Bed Board that shows availability at the various levels of care in the system would allow for collaboration and movement of patients. The use of a universal assessment tool also facilitates getting patients to the correct level of care.

12. Can you provide an on-site facility for court hearings?

With the renovations proposed we can certainly provide on-site space for court hearings. We addressed that need as a secure access courtroom in our proposal.

13. What would you do differently from current practice to manage higher acuity and a zero-reject admission policy in the proposed program?

The solutions to the current barriers at the Windham Center related to higher acuity and a zero-reject admission policy are addressed in our proposal. The Windham Center leadership has a familiarity with dealing with higher acuity patients in settings where the infrastructure exists to support such care. The Windham Center would need to implement that infrastructure which is outlined in the proposal. Implementation would include a reconfiguration of the space to support caring for highly acute individuals, space within which to provide an environment to assess a patient prior to placing them in the milieu if they are highly acute, on site security, onsite medical capabilities, and an increase in staffing levels.

14. What community resources and or step-down services are needed for this program to succeed? Please respond both in the context of your immediate community and statewide.

From a statewide perspective the resources needed to for this program to succeed include a well-functioning care management process with excellent teamwork across the system. A well functioning utilization management system to facilitate flow to multiple resources would be necessary. We would look for good collaboration from the Department of Mental Health, the Designated Hospitals, and the Designated Agencies to help the program be successful and work toward solutions for any glitches that may arise.

From a local community perspective we would need to maximize the capacity for local CRT services to be able to wrap around clients quickly in the community and to admit new CRT clients quickly. The development of the intensive case management for non-CRT clients would be a necessity for the success of the program we are proposing. A mechanism for transitional housing would help to move clients more reasonably quickly through the crisis stabilization level of care.

15. **Please specify how you would meet the full psychiatric needs of patients with complex and difficult medical conditions (e.g. the importance of program milieu and how that could be met at Springfield Hospital).**

    The proposed space layout and programming is designed to be able to individualize programming for a diverse array of patients. The Windham Center currently works with a diverse array of patient needs. We would have the capacity to create subunits within the milieu to facilitate this. We have also included the medical capacity in space and staffing to care for patients with psychiatric and medical conditions on site. If a patient needed to be transferred to Springfield Hospital for more intense medical care psychiatry would be available to consult with the medical physicians and Windham Center staff could also be scheduled at the hospital to attend to the patient's psychiatric needs. On some occasions, based on patient need, we have already implemented such a plan.

16. **How would the inpatient service manage different patient needs and groups (gender, acuity, diagnosis, behavior) within the proposed program?**

    Our programming would be based on a strength based recovery model. Once patients were on the unit we would partner with them in the process of figuring out what they need to learn to be successful. Such an approach allows for the accommodation of very diverse groups in the milieu. Some patients may not be attending groups due to their acuity and choice. Some patients may be medically or cognitively impaired requiring more individualized attention.

17. **How do you see this proposed program as part of the larger system to insure that every patient has a bed even if your program is at capacity?**

    The Windham Center is willing to work with the Department of Mental Health within the utilization management system and the care management system. As we stated in our proposal and throughout the response to these questions we believe patients should be in the appropriate setting to meet their needs. If we were to have patients who were ready to transition and there was pressure on the system for beds we are willing to work within the care

management system to move the patient on to the next level of care that will meet their needs.

18. How would the proposed renovations be capitalized?

Our goal to finance the proposed renovations is to enter into a partnership with the Department of Mental Health and the State of Vermont.

19. Are there any statutory changes you feel would be necessary or important to the proposed program's success? (For instance, non-emergency involuntary medication, admission of court ordered evaluations without physician order and retain in hospital post physician recommendation?)

We have based our proposal on the idea that the above mentioned changes may not be forthcoming or may take a period of time to implement. Although, the changes might be helpful we have not created our proposed program around those changes.

20. How do you define acute care and how would the needs of patients who may stay for long periods of time be met?

The Windham Center would agree with the definitions of acute care used in the LOCUS assessment tool. A systematized approach to assessment and client placement across the continuum of care we are proposing and the statewide continuum of care would be supported by the Windham Center. Currently, our average length of stay at the Windham Center is between 7 and 8 days. We on occasion have patients who need our care for up to 60 days or more. Although the longer lengths of stay can be challenging in managing the number of admissions we like to care for we certainly have done it and provided excellent care. We think it is important to be partnered with the Department of Mental Health and other providers in the state so that the VSH replacement beds do not get backlogged with patients needing different levels of care. We are thinking that the VSH replacement beds we are proposing would have an average length of stay no greater than 30 days.

21. How would the intensive case management team be funded and would it operate statewide (or is it a local resource)?

We would implement Intensive Case Management as a resource for clients in our service area. For individuals who are non-CRT who are returning to other communities this sort of team would be helpful, however, we are not proposing to provide the service in other communities. One of our thoughts is that this service might be supported by billing some sort of ICSS and that funds would be provided to support that option. We feel that Intensive Case Management may allow some individuals to decrease the need for hospitalizations and the use of more costly services if appropriate support and

intervention can be provided proactively before the client is in crisis and as they are discharged from hospitalization or crisis stabilization.

22. Is it realistic that one peer specialist per shift could meet the needs of highly acute patients?

We are very much willing to look at increasing the staffing pattern of peer specialists. We appreciate you bringing this to our attention and are willing to collaborate on what might be a more appropriate ratio for peer specialists.

23. What will you require for medical clearance prior to admission and can you be flexible especially if a patient is refusing medical care or evaluation?

The Windham Center is supportive of the medical clearance policy put forth in the consultants' Report on Clinical Services Design. We plan to remain active in the Representative Steering Committee and to participate in creating parameters for medical clearance. We are willing to be flexible if a patient is refusing medical evaluation as long as they do not have a high-risk medical situation such as an overdose. Included in our proposal is on site medical support. We would have those services available to the patient at the point they were then willing to be evaluated.

24. Please clarify-does each patient bedroom have a private bathroom?

Each patient room has a bathroom that includes a sink and toilet. Shower facilities are available on the unit.